

Vacation Prescription Request

Name: _____

Member ID number: _____

Phone: _____

Vacation Destination: _____

Departure Date: _____

Returning: _____

Signature of patient: _____

Name of drug(s): _____

This form is for use when a short-term vacation leaves you without access to a CVS Pharmacy or other participating pharmacy to meet your needs away from home.

Vacation requests for medications are not intended for extended periods. **However, if this request is due to deployment, school or work related travel, please also submit the corresponding documentation to confirm the need for an extension.** If your vacation prescription request is approved, the Plan will allow one fill per medication. If your vacation prescription request is **not** approved, or if you must purchase medications while on vacation, refer to the Plan's current brochure for instructions on obtaining reimbursement using the short-term prescription claim form.

Please leave a good callback number for the Plan to call when your request is completed.

Fax to the attention of the NALC CDHP Department at **(703) 729-0076**.

Controlled medications may require additional information.